Western Maryland Physician Network, LLC
MDCTO-0092
Summary Information

Maryland Primary Care Program, 2018 Application Cycle

CTO Overview

CTO Information				
Application ID Number	MDCTO-0092			
Status of the Proposed CTO	The proposed CTO is owned and operated by a healthcare organization and is currently in existence.			
Organization Site Name	Western Maryland Physician Network, LLC			
DBA Name	Western Maryland Physician Network, LLC			
Website (if applicable)	N/A			
Ownership & Legal Structure				
Owned by Health Care Organization	Yes			
Name of Parent Organization	Western Maryland Health System			
Legal Structure	Non profit 501: Western Maryland Health System is a not-for-profit community health system			
Service Area				
Counties Served	Allegany County; Garrett County			
Partnerships				
Formal Partnerships	Allegany County Health Planning Coaltion Trivergent Health Alliance Regional Partnership Partnership to Perfection with area skilled nursing facilities			
Informal Partnerships	N/A			
Services Offered				
Tele-diagnosis	Planned for future			
Tele-behavioral health	Currently in place			
Tele-consultation	Planned for future			
Remote Monitoring	Currently in place			
Other	N/A			
HIT				
CRISP Connectivity	We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).; We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.; We use CRISP to view data.; We send administrative encounter data to CRISP on a regular basis.; We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.			
HIT Vendor	Dimensional Insight	Meditech	eClinical Works, LLC	eClinicalWorks, LLC
HIT Product Name	Diver Platform	Meditech Magic	eClinicalWorks	eClinicalWorks CCMR

Care Team Members

Category	Currently in place: How many?	Planned for future: How many?
Administrative Support	1	N/A
Behavioral Health Counselor	1	3
Billing/Accounting Support	1	N/A
Care Managers - RNs	3	6
Care Managers - Medical Assistants	N/A	N/A
Care Managers - Other	3	6
Community Health Workers	2	4
Data Analysts	N/A	1
Health IT Support	1	N/A
Licensed Social Workers	1	2
Nutritionist	2	3
Pharmacists	N/A	2
Practice Transformation Consultants	1	N/A
Psychiatrist	1	N/A
Psychologist	N/A	1
Other	N/A	N/A

Vision

The Western Maryland Physician Network (WMPN) was formed to promote deeper integration with providers by providing highly coordinated, patient-centered care resulting in improved clinical outcomes, patient satisfaction, and better heath for patients at a lower cost. WMPN participated in the MSSP from 2015-2017. During these years, WMPN provided care coordination and administrative oversight to its members, along with IT, education, and reporting support for quality metrics, MACRA education, and PCMH consultation. WMPN physician leaders also assisted with the review of quality metrics for the ACO, earning very high scores. WMPN members may utilize the Center for Clinical Resources (CCR), an integrated care model, addressing high-risk, multiple co-morbidity patients, created by the Western Maryland Health System. Disciplines represented are social work, care management, behavioral health, community health workers, navigators, dietitians, pharmacists, respiratory therapists, and CRNPs specializing in chronic disease management. The CCR is a trusted partner with our PCPs and will be a major source of referral for MDPCP patients. WMPN members partner with various area agencies to meet needs including food, housing, prescription medication, health insurance, transportation, and access to care. WMPN believes that a patient's care is not only impacted by his medical team, but also how this team relates to/engages with the patient and family. Patient engagement is giving patients the tools they need to understand what makes them sick, how to stay healthy, and what to do if conditions change. WMPN members have access to the CCR and collaborate with the same community partners. Two cornerstones of WMPN success have been the implementation of outpatient care coordination and patient centered medical home model. PCMH supports access and continuity, beneficiary and caregiver experience, care management, comprehensiveness and coordination, and planned care for health outcomes. PCMH works with patients and their families to ensure that they receive the appropriate care in the most appropriate setting. Our approach to care coordination is a collaborative, patient-centered one that is based in primary care and moves across the care continuum, with special emphasis during care transitions. PCMH will deliver primary care and connect beneficiaries to medical specialists and other appropriate resources in the CTO and in the community. Emphasis will be placed on scheduling patients for annual wellness visits and appropriate screenings, along with other preventive services. Personalized prevention plans will be developed and patients will be connected to the CTO and community-based services to manage their risk factors and/or chronic conditions. Care plans will be based on proven clinical guidelines that outline needs and goals. Access to shared information by all providers is essential to improve the patient experience through the care continuum, provide timely access to care, reduce duplication of effort and ensure high-quality patient-tailored care. The CTO will use a hospital-based product, Dimentional Insights to extract data from various EHRS and CRISP to bridge the data sharing gap across the continuum. IT staff will also work with CTO providers to ensure data is being appropriately shared throughout the network. Care plans and other data will be available to all members of the care team. The CTO will use a variety of mechanisms to assess care coordination and improve care practices, including CGCAPS, as well as quality and cost metrics. In summary, the WMPN has a successful track record of assisting practices in meeting the care transformation requirements. WMPN has, and will, continue to enhance the capacity of practices to provide care management services, improve workflows, and manage their populations across the care continuum, leading to improved quality, lower costs, and a healthier population.

Approach to Care Delivery Transformation

Our approach to care coordination is a collaborative, patient-centered one that is based in a primary care medical home and moves across the continuum of care, with special emphasis during transitions of care. WMPN will have comprehensive strategies in place to coordinate the care of the patients it serves. The dynamic process will use a variety of metrics to measure the impact of care coordination on hospital utilization, as well as cost savings. The strategy is to decrease costs by providing more comprehensive and coordinated care, particularly for patients with the highest risks and expenses. The central source of coordination will be through the PCMH, which will connect beneficiaries to medical specialists and other community resources. Emphasis will be placed on annual wellness visits and appropriate preventive services and screenings. Personalized plans will be developed and patients will be connected to community-based services to manage their risk factors and/or chronic conditions. Patients will receive individualized care plans based on proven clinical guidelines. Data analytics will identify high risk patients who will be referred to the appropriate services, such as the Center for Clinical Resources (CCR). The interdisciplinary team approach in the CCR enhances the coordination of care for those patients who have one of more chronic health conditions. Diabetes, heart disease and COPD are prevalent in our region and addressing these conditions was the basis for the design and implementation of the CCR. All care coordinators have access to a community resource guide that can assist with addressing the needs of the Medicare population. As a former Medicare Shared Savings Program participant, WMPN care coordinators have had three years of experience in developing a comprehensive care coordination approach.